ARC 7718B

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)*"b."*

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services proposes to amend Chapter 75, "Conditions of Eligibility," Iowa Administrative Code.

The proposed amendments make technical changes to clarify and update policy for the Medicaid Health Insurance Premium Payment (HIPP) program to reflect the changing health insurance picture in the public domain. The changes:

• Clarify the two types of plans (group and individual) and the differences in their policy treatment.

• Specify a definite period (12 months) for considering past claims for the cost-effectiveness determination.

• Eliminate the cost-effectiveness determination deemed for certain types of plans based on low monthly premiums or pregnancy. The cost-effectiveness of these plans would be assessed using the same methodology applied to all other plans. This methodology takes into account the cost to Medicaid for the plan deductibles, which can sometimes be $5,000 to $10,000.

• Correct program names, rule cross references, form names and numbers, and references to policies that are no longer in effect.

These amendments do not provide for waivers in specified situations because the Department believes these technical amendments, clarifications, and updates should apply in all cases. However, requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

Any interested person may make written comments on the proposed amendments on or before May 13, 2009. Comments should be directed to Mary Ellen Imlau, Bureau of Policy Analysis and Appeals, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by E-mail to policyanalysis@dhs.state.ia.us.

These amendments are intended to implement Iowa Code section 249A.3.

The following amendments are proposed.

ITEM 1. Amend rule 441—75.21(249A) as follows:

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care ~~directly.~~ through Medicaid. Payment shall include only the cost to the Medicaid member or household.

75.21(1) *Condition of eligibility for group plans.* The ~~recipient,~~ Medicaid member or a person acting on the ~~recipient's~~ member's behalf~~,~~ shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of a group health ~~insurance~~ plan. ~~Persons who are eligible to enroll in a group health insurance plan which~~ When the department has determined that a group health plan is cost-effective, ~~and who are otherwise eligible for Medicaid, shall apply for~~ enrollment in the plan ~~as~~ is a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid ~~eligible persons~~ members through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

a. When a parent fails to provide information necessary to determine availability and cost-effectiveness of a group health ~~insurance~~ plan, fails to enroll in a group health ~~insurance~~ plan that has been determined cost-effective, or disenrolls from a group health ~~insurance~~ plan ~~the department~~ that has been determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established.

b. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

~~*a.*~~ (1) There was a serious illness or death of the parent or a member of the parent's family.

~~*b.*~~ (2) There was a family emergency or household disaster, such as a fire, flood, or tornado.

~~*c.*~~ (3) The parent offers a good cause beyond the parent's control.

~~*d.*~~ (4) There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

c. Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of ~~the~~ a spouse ~~of the employed person~~ who cannot enroll in the plan independently of the other spouse shall not be terminated due to the ~~employed person's~~ other spouse's failure to cooperate ~~when the spouse cannot enroll in the plan independently of the employed person~~.

d. The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

75.21(2) ~~*Non-employer related*~~ *Individual health insurance plans.* Participation in ~~a~~ an individual health ~~insurance~~ plan ~~that is not group health insurance as defined in rule 441—75.25(249A)~~ is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

a. A household member is currently enrolled in the plan; and

b. The health plan is cost-effective as defined in 75.21(3).

75.21(3) *Cost-effectiveness.* Cost-effectiveness for both group and individual plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under ~~an insurance~~ the health plan for those services. When determining the cost-effectiveness of the ~~insurance~~ health plan, the following data shall be considered:

a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. ~~An employer-related group health insurance plan that provides major medical coverage and costs $50 or less per month shall be determined cost-effective when establishing eligibility for one-person Medicaid-eligible households. An employer-related group health insurance plan that provides major medical coverage and costs $100 or less per month shall be determined cost-effective when establishing eligibility for households of two or more Medicaid-eligible persons.~~ No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

b. The scope of services covered under the ~~insurance~~ health plan, including but not limited to exclusions for preexisting conditions~~, etc~~.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for ~~persons~~ members covered under the ~~insurance~~ health plan.

d. The specific health-related circumstances of the ~~persons~~ members covered under the ~~insurance~~ health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. ~~Employer-related group health insurance plans that provide major medical coverage shall be determined cost-effective when there is a Medicaid-eligible pregnant woman who can be covered under the plan.~~ When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of $50 per Medicaid ~~recipient~~ member covered under the health ~~insurance policy~~ plan.

f. Whether the estimated savings to Medicaid for ~~persons~~ members covered under the health insurance plan are at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.*

a. When ~~it~~ a group plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However~~,~~:

(1) ~~the~~ The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) ~~payments~~ Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

75.21(5) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. to *e.* No change.

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for ~~limited~~ a coverage group that does not provide full Medicaid services ~~under~~, such as the specified low-income Medicare beneficiary (SLMB) coverage group~~,~~ in accordance with subrule 75.1(34) or the IowaCare program in accordance with the provisions of 441—Chapter 92. Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the ~~Iowa Comprehensive Health Insurance Association~~ Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. and *j.* No change.

k. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

l. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

m. The health plan pays secondary to another plan.

n. The only Medicaid members covered by the plan are currently in foster care.

o. All Medicaid members covered by the plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

75.21(6) *Duplicate policies.* When more than one cost-effective health ~~insurance~~ plan ~~or policy~~ is available, the department shall pay the premium for only one plan. The ~~recipient~~ member may choose ~~in which~~ the cost-effective plan in which to enroll. ~~However, in situations where the department is buying in to the cost of Medicare Part A or Part B for eligible Medicare beneficiaries, the cost of premiums for a Medicare supplemental insurance policy may also be paid if the department determines it is likely to be cost-effective to do so.~~

75.21(7) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review ~~shall be completed~~ in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If ~~it is determined~~ the department determines that the ~~policy~~ health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the ~~policyholder~~ household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the ~~insurance coverage~~ health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health ~~insurance plans~~ plan shall be determined as follows:

a. Premium payments shall begin no earlier than the later of:

(1) ~~the~~ The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, ~~or~~ the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the ~~division of medical services~~ HIPP unit; or

(2) ~~the~~ The first day of the first month in which the plan is determined to be cost-effective~~, whichever is later~~.

b. If the person is not enrolled in the plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the ~~policy~~ health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time ~~prior to~~ before the current effective date of coverage.

d. In no case shall payments be made for premiums ~~which~~ that were used as a deduction to income when determining client participation~~,~~ or the amount of the spenddown obligation~~, or for premiums due for periods of time covered prior to July 1, 1991~~.

e. The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and ~~premiums~~ costs for persons enrolled in group ~~health insurance~~ plans through an employer.

f. The effective date of coverage for individual plans or for group plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(9) *Method of premium payment.* Payments of ~~health insurance~~ premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to ~~the~~ an employer in order to circumvent a payroll deduction.

b. When ~~the~~ an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the ~~policyholder~~ employee directly for payroll deductions or for payments made directly to the employer for the payment of ~~health insurance~~ premiums. The department shall issue reimbursement to the ~~policyholder~~ employee five working days ~~prior to~~ before the ~~policyholder's~~ employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for ~~said~~ those withdrawals.

d. ~~When the department is otherwise unable to make direct premium payments because the health insurance is offered through a contract that covers a group of persons identified as individuals by reference to their relationship to the entity, the department shall reimburse the policyholder for premium payments made to the entity.~~ Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

75.21(10) No change.

75.21(11) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility shall be completed annually ~~or~~ and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the ~~next~~ health ~~insurance~~ plan contract renewal date ~~for employer-related group health plans. Reviews may be conducted more frequently at the discretion of the department.~~ The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, ~~shall be used~~ for ~~this purpose~~ the review.

b. ~~Reviews of cost-effectiveness shall be completed annually for non-employer-related group~~ For individual health plans~~. The recipient shall sign the Insurance Carrier Authorization to Release Information, Form 470-3015, as part of the review of non-employer-related plans so that the department may obtain pertinent information necessary to establish continued eligibility~~, the client shall complete HIPP Individual Policy Review, Form 470-3017, for the review.

c. Failure of the ~~policyholder~~ household to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

d. Redeterminations shall ~~also~~ be completed whenever:

(1) ~~a predetermined~~ A premium rate, deductible, or coinsurance ~~increases~~ changes,

(2) ~~some of the persons~~ A person covered under the policy ~~lose~~ loses full Medicaid eligibility,

(3) ~~employment terminates or hours are reduced which affects~~ Changes in employment or hours of employment affect the availability of health insurance,

(4) ~~the~~ The insurance carrier changes,

(5) ~~the~~ The policyholder leaves the Medicaid home, or

(6) ~~there~~ There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person. ~~A~~ The department sends a HIPP Change Report, Form 470-3007, ~~shall accompany~~ with all premium payments.

f. If a change in the number of members in the Medicaid household causes the plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(16)*"a,"* shall be considered if available and cost-effective.

g. When employment ~~terminates~~ ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health ~~insurance coverage~~ plan occurs, the department shall verify whether ~~insurance~~ coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other ~~insurance~~ coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for ~~eligible~~ Medicaid ~~recipients~~ members after the occurrence of the ~~qualifying~~ event which would otherwise result in termination of coverage.

75.21(12) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the ~~insurance~~ health plan and notify the ~~recipient~~ applicant of the decision regarding payment of the premiums within 65 calendar days from the date an ~~Employer's Statement of Earnings, Form 470-2844, indicating the availability of group insurance or a Health Insurance Premium Payment Application, Form 470-2875,~~ application or referral (as defined in subrule 75.21(8)) is received. Additional time may be ~~granted~~ taken when, for reasons beyond the control of the department or the ~~recipient~~ applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.*

a. An adequate notice shall be provided to the household under the following circumstances:

~~*a.*~~ (1) To inform the household of the initial decision on cost-effectiveness and premium payment.

~~*b.*~~ (2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the ~~policy~~ health plan.

~~*c.*~~ (3) The ~~policy~~ health plan is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household ~~informing them~~ of a decision to discontinue payment of the health insurance premium because:

(1) ~~the~~ The department has determined the ~~policy~~ health plan is no longer cost-effective, or ~~because the~~

(2) ~~recipient~~ The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) No change.

75.21(15) *Reinstatement of eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the ~~policy~~ health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the ~~recipient's~~ member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(16) *Amount of premium paid.*

a. For group plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(17) *Reporting changes.* Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.

ITEM 2. Rescind the definition of "Group health insurance" in rule **441—75.25(249A)**.